

2011 Military Health System Conference

Ventilator Associated Pneumonia: Targeting Zero

The Quadruple Aim: Working Together, Achieving Success

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Honolulu, Hawaii

Tripler Army Medical Center



-239 bed Tertiary Care facility

*264,000 local active duty, retiree, family members, VAB

*171,000 referral population

Adult Intensive Care Unit

-15 bed medical/surgical ICU

-Average census: 11.5 beds/day

- Average LOS: 3.1 days

-Average ventilator days/month: 116

Technical Work



- Addresses problems for which the definition is clear, the potential solutions are reasonably clear and usually require little or minimal learning
 - Institute for Healthcare Improvement bundle
 - Silver coated endotracheal tube
 - Reinforced the ABC weaning protocol
 - New closed suctioning system

Adaptive Work



- Addresses problems that require a change in attitudes, beliefs, and behavior
- Involves shared responsibility for change: leaders share responsibility with organizational staff and key stakeholders
- Most common error
 - Treating an adaptive problem as technical



Comprehensive Unit-Based Safety Program (CUSP)



Improve safety culture & learn from mistakes
by integrating safety practices

How can we improve



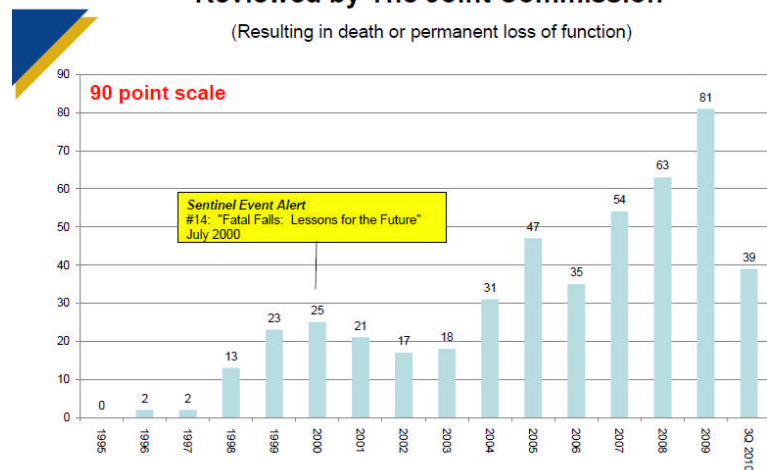
“Every system is perfectly designed
to achieve the results it gets”

Sentinel Event Data



Fall-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



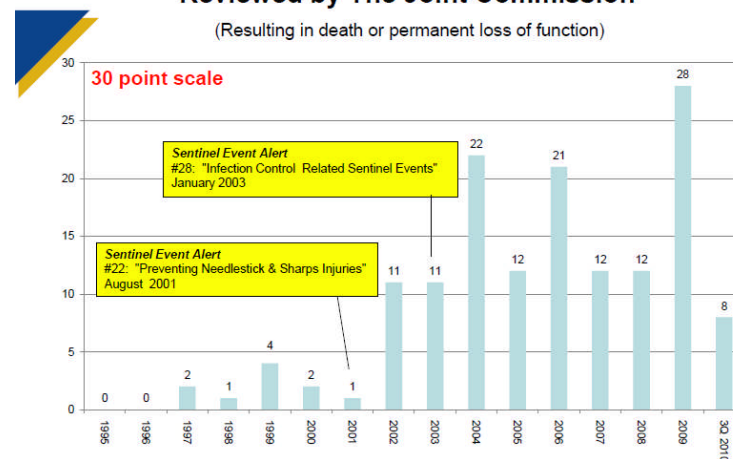
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

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Infection-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



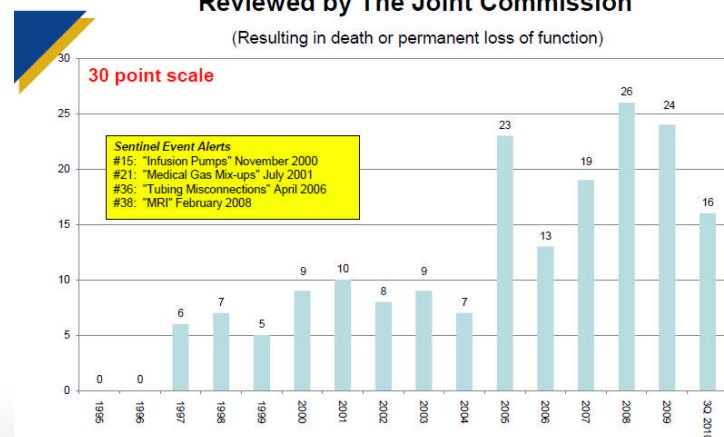
The Joint Commission

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Medical Equipment-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



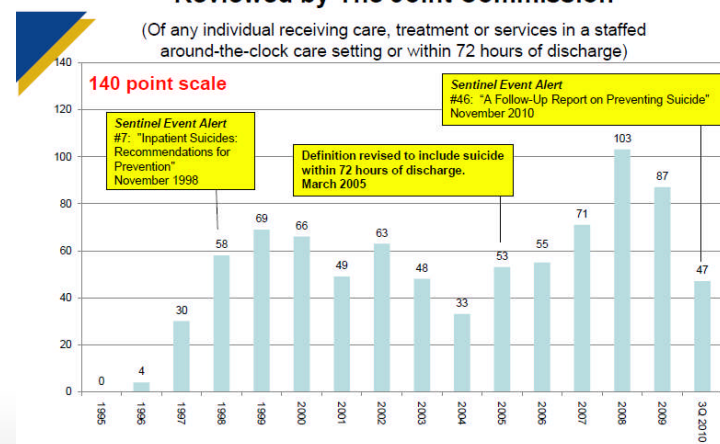
The Joint Commission

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Suicide Events Reviewed by The Joint Commission

(Of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge)



The Joint Commission

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Steps of CUSP



- Educate staff on Science of Safety
- Identify defects
 - Clinical or operational that you do not want to happen again
- Assign executive to adopt unit
 - Communication, attitudes, resources
- Learn from one defect per quarter
- Implement teamwork tools

So where are we now...



Summary



- Is a continuous process
- No longer just an “unfortunate” occurrence
- No longer satisfied to be below the national mean
 - Mean anchored us to mediocre performance
- Goal now is to strive for “zero”



MAHALO!

(Thank you!)

